Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

PHARMACY EXAMINING BOARD

PHARMACY CLOSING AFFIDAVIT

☐ CHANGE OF OWNERSHIP ☐ OUT OF BUSINESS ☐ CHANGE OF LOCATION

☐ REMODEL Closing Date: _____

Please TYPE or PRINT in INK

I hereby certify the below named pharmacy closed on _____ and the following action was taken:
(date)

PHARMACY: _____

ADDRESS: _____
number, street

_____
city, state, zip code

LICENSE #: _____

Managing R.Ph. _____

License #: _____

Contact Phone #: _____

ALL NON-CONTROLLED PRESCRIPTION DRUGS REMOVED FROM PREMISES AND RECEIVED BY:

NAME: _____

ADDRESS: _____

_____

LICENSE #: _____

TRANSFERRED PRESCRIPTION FILES TO:

NAME: _____

ADDRESS: _____

_____

LICENSE #: _____

ALL CONTROLLED DRUGS SUBJECT TO FEDERAL CONTROLLED SUBSTANCES ACT DISPOSED OF IN ACCORDANCE WITH 21 CFR 1307.21.

Transferred to:

Name: _____

Address: _____

Date of Final Inventory _____

Date of Transfer _____

FED. CSA REG. NO. _____

DEA Form #222 _____ YES _____ NO

1. Removed all drug signs and all symbols, insignia, etc., indicating the presence of a pharmacy. (For out of business pharmacies only. Not required for remodel requests.)

_____ YES _____ NO _____ N/A If yes, date: _____

Wisconsin Department of Regulation & Licensing

2. Informed the telephone company in writing to remove all listings from the classified telephone directory. A copy of the letter is attached. (For out of business pharmacies only. Not required for remodel requests.)

   _____ YES _____ NO

3. Discontinued use of checks, stationery, wrapping paper, bags, etc., containing the words drugs, pharmacy, etc., or symbols indicating the operation of a pharmacy or the sale of drugs. (For out of business pharmacies only. Not required for remodel requests.)

   _____ YES _____ NO _____ N/A If yes, date: _____

4. Current pharmacy renewal license is enclosed. (For out of business pharmacies only. Not required for remodel requests.)

   _____ YES _____ NO

5. Forward a copy of this affidavit, DEA Certificate of Registration, and any unused DEA Form 222 Order Forms to: DEA, Attn: Registration, 230 S. Dearborn St., # 1200, Chicago, IL 60604. (For out of business pharmacies only. Not required for remodel requests.)

AFFIDAVIT OF MANAGING PHARMACIST

The undersigned, having been duly sworn on oath, states that the facts and statements herein contained are true and correct based upon personal knowledge of the undersigned.

_____ _____

Managing Pharmacist Signature Date

State of _____

County of _____

Subscribed and sworn before me this _____ day of

_____, 20_____

by _____ ***SEAL***

_____

Notary Public, State of _____

My commission expires: _____

NOTE: This affidavit must be signed by the Managing Pharmacist in the presence of the notary public on the same date.